DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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Innovation Center Idea Assessment Factors

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Below you will find a description of the factors the Innovation Center considers in assessing whether a payment or service delivery model will benefit Medicare, Medicaid and CHIP beneficiaries and deliver on the three part aims of better care, improved health, and reduced costs through improvement. In addition to the assessment factors below, please refer to the Innovation Center's Portfolio Criteria for guidance.

We are interested in testing models that address gaps in care and delivery systems, reimbursement or other barriers to quality care.

We are interested in models that can improve health care quality and reduces expenditures from the Medicare, Medicaid or CHIP programs. In particular, we are interested in testing models that can be quantified in terms of the scale of quality improvement and expenditure reduction, and we are interested in models that benefit various identifiable populations or subpopulations of Medicare, Medicaid or CHIP beneficiaries.

We will assess models for testing based on whether they have a clearly articulated hypothesis that supports how the behavior of clinicians, patients, or others will change or why those behavior changes will result in lower costs and better quality. In particular with respect to payment models, we are interested in those that address various types of payment systems (e.g., fee for service with pay for performance, shared savings, partial capitation, etc.).

We are specifically interested in models that may have some existing evidence that helps inform our decision making about the scope of testing. This would include evidence to support further design development, evidence to warrant limited testing (i.e., smaller scale or geographic scope), or evidence to support a large scale initiative. We also will consider the geographic scope of a potential model (e.g., national, statewide, or regional) and the type of areas (e.g., urban or rural), if applicable, in which the model is to be tested.

The models we select will identify the types and numbers of clinicians (e.g., physicians, pharmacists, etc.) and institutions (e.g., hospitals, inpatient rehabilitation facilities, skilled nursing facilities, etc.) who would participate in this model.

We will consider models that target specific health conditions, diseases, or specific populations (e.g., high cost users, populations served by safety net providers). We would consider models that include various types of beneficiaries (e.g., for Medicare beneficiaries, those in Medicare Advantage as well as Original Medicare).

- We are also interested in models that that include other payers or can be implemented by other payers, such as other federal payers (e.g., Tricare, FEHBP)
- Other public payers (e.g., state employee programs)
- Commercial private payers (e.g., health plans or employers)

We are looking for models that align efforts across multiple payers to promote delivery system reform and are particularly interested in models that can measure and foster positive impacts for both CMS beneficiaries and others.

Part of our assessment of a model will include a determination about the appropriate timeframe within which the model might generate measurable results. We envision that some models could be evaluated in less than 1 year, while others might be evaluated after 1 year, 3 years, 5 or more years or on a longer-term basis.